What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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HEALTH ON WHEELS

Ever since the Alma Ata Conference in 1978, Government of Ghana policies have called for placing trained Community Health Nurses (CHN) in village locations where over 70 percent of the population resides. The cost of constructing clinics is high, however, and CHN that have been trained for community work typically work in Level B clinics that are inaccessible to most rural households. It is clear that building more clinics and hospitals will not bring health to rural households.

Hospital in a knapsack

To address the need for partnership in community health, village leaders were approached by the Community Health and Family Planning (CHFP) project prior to fieldwork and asked to convene an open forum for the discussion of health service needs.[1] Without exception, every community asked the CHFP to "provide a clinic." Since funds were not available for construction of clinics in every village, agreements were developed whereby each community contributed labour or materials for constructing a traditional compound (termed the Community Health Compound (CHC).[2] Once CHC were ready, nurses could be reposted to communities where they lived and worked. Nurses were trained in community diplomacy and health education, reoriented to new management information systems, and retrained in health technologies. Since motorbikes were needed, a training course was provided in motorbike riding and care. These upgraded Community Health Nurses were redesignated as Community Health Officers (CHO) to emphasize their status as upgraded workers. Relocating nurses involved more than constructing CHC and issuing administrative orders. Support systems were developed for assuring that workers had technical, community, supervisory, and peer support, as follows:

Technical support. Introducing the CHO model represents an opportunity to improve technical competence through training. CHO were trained in midwifery, a component of care that was missing from the CHN programme. Delivery care and Traditional Birth Attendant (TBA) training are essential elements of community-based care. CHO were also trained in basic diagnostic services, referral, and treatment care. Most importantly, CHO were trained in community entry, diplomacy, counseling, and work planning, all of which represent essential elements of community-based care. Both facilitators and participants evaluated training courses; each course was associated with a report. Training emphasized field-based practical training for problems that workers encounter during the course of village-based service delivery.

Community Health Compound (CHC)

Supervisory support. Too often supervision is interpreted as a programme of checking on subordinates, policing work, and correcting mistakes. From the onset of CHFP operations, there has been recognition of the need to develop supervisory systems that avoid this mechanical and demoralizing approach to supervision

[1] The CHFP is a collaborative program of field research involving service delivery supervised by the Kassena-Nankana District Health Management Team and research conducted by the Navrongo Health Research Centre.

[2] The CHC initiative will be described in other *What works?* notes. Also, other notes will focus on detailed lessons learned about posting nurses to village locations.

through a process whereby managers visit subordinates to see how they are working in their own environment and to offer assistance to them. Assistance may involve organizing meetings with community leaders to discuss problems, arranging equipment repair or replacement, advising on health care service activities and needs, and linking CHO with their peers for exchanges and collaborative support.

CHO being introduced to the community

Community support. A key element of the success of the CHO programme has been to address worker needs for continuous support. Doorstep service delivery can place workers in the middle of community problems that require urgent attention. Moreover a worker who lives in the village may have essential needs that cannot be addressed without community support: Facilities maintenance for the CHC, water for household chores, security needs that require organized support, and diplomatic needs that may call for the intervention of chiefs and elders.

Peer support. Peer support is the process whereby workers at one level of a work system provide advice, support, and leadership to colleagues at the same level of the system. CHO benefit greatly from contact with each other. Carefully planned exchanges can reduce the sense of isolation and vulnerability that goes with living in a village and working alone. Exchanges, organized as meetings, encourage the sharing of information, mutual advice on problem solving, and peer leaderships to improve the quality and efficiency of heath care. In recent years, CHO trainees have been assigned to work with experienced CHO. This programme of peer exchange and peer leadership is viewed as an important element of the CHO support system.

Familial support. CHO who are assigned to CHC are removed from relatively comfortable MOH provided housing at the sub-District Health Centre and assigned to villages without moving their families. At the initial stages, CHO were posted to villages without prior discussion with the affected spouses. Establishing familial support has been a critical element to the smooth running of the programme. Meetings to liaise with spouses, hear their concerns, and respect family needs have been crucial to the success of the CHO initiative. Husbands often have no experience in cooking and minimal involvement in child care. Conventional gender-stratified roles therefore constrain the initiative. Moreover, posting a nurse to a village has real costs associated with it: CHO had to buy utensils, flashlights, and personal supplies that turned out to be too costly for affected families to bear. The CHFP therefore developed a "settling-in kit" to provide essential household effects. In keeping with policies of the Ghana Educational Service, a small community hardship allowance is paid to defray the cost of operating two residences, arranging support for child care, or other family needs.

Conclusion. Placing a nurse in a CHC involves more than issuing instructions and supervising activities. Support systems are required that deal with the impact of this programme on CHO personal lives. Relocating nurses to villages will fail if nurses are left on their own. However, the CHFP has demonstrated ways in which this relocation programme can succeed by supporting workers at the periphery.

CHO in the community

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.